		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026435

Facility Name: Alden Wentworth Rehab & HCC

Address: 201 W. 69th St. (Number) Chicago (City) 60621 (Zip Code)

County: COOK

Telephone Number: (773) 487-1200 **Fax #** (773) 487-4782

IDPA ID Number: 36-2975641

Date of Initial License for Current Owners: 09/09/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Steven M. Kroll

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,198	733	287	16,218	8
9	SNF/PED					9
10	ICF	53,882	705	2,585	57,172	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69,080	1,438	2,872	73,390	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.84%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/09/81

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 17 and days of care provided 1,670

Medicare Intermediary Administar Federal Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	284,218	49,914		334,132	710	334,842		334,842			1
2	Food Purchase		418,948		418,948	(41,438)	377,510	(38,900)	338,610			2
3	Housekeeping	264,021	37,109		301,130	912	302,042		302,042			3
4	Laundry	77,324	23,207		100,531	690	101,221		101,221			4
5	Heat and Other Utilities			223,552	223,552		223,552		223,552			5
6	Maintenance	35,821		194,294	230,115	1,517	231,632	23,390	255,022			6
7	Other (specify):*											7
8	**TOTAL General Services**	661,384	529,178	417,846	1,608,408	(37,609)	1,570,799	(15,510)	1,555,289			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,141,549	77,246	14,710	2,233,505	5,372	2,238,877	(405)	2,238,472			10
10a	Therapy					152	152		152			10a
11	Activities	78,994	8,247	2,524	89,765		89,765		89,765			11
12	Social Services	29,634		824	30,458		30,458		30,458			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*					320	320		320			15
16	**TOTAL Health Care and Programs**	2,250,177	85,493	30,058	2,365,728	5,844	2,371,572	(405)	2,371,167			16
	C. General Administration											
17	Administrative	89,631			89,631		89,631		89,631			17
18	Directors Fees											18
19	Professional Services			1,030,496	1,030,496		1,030,496	(962,147)	68,349			19
20	Dues, Fees, Subscriptions & Promotions			41,761	41,761		41,761	(28,551)	13,210			20
21	Clerical & General Office Expenses	558,480	19,538	28,251	606,269		606,269	74,338	680,607			21
22	Employee Benefits & Payroll Taxes			460,879	460,879	33,248	494,127	73,604	567,731			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,543	1,543		1,543	19,334	20,877			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,883	62,883		62,883	205	63,088			26
27	Other (specify):*			18,000	18,000		18,000	(18,000)				27
28	**TOTAL General Administration**	648,111	19,538	1,643,813	2,311,462	33,248	2,344,710	(841,217)	1,503,493			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,559,672	634,209	2,091,717	6,285,598	1,483	6,287,081	(857,132)	5,429,949			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Wentworth Rehab & HCC #0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			69,695	69,695		69,695	174,420	244,115			30
31	Amortization of Pre-Op. & Org.							957	957			31
32	Interest			57,636	57,636		57,636	254,769	312,405			32
33	Real Estate Taxes			349,349	349,349		349,349	8,380	357,729			33
34	Rent-Facility & Grounds			1,176,050	1,176,050		1,176,050	(1,176,050)				34
35	Rent-Equipment & Vehicles			12,002	12,002		12,002	2,653	14,655			35
36	Other (specify):* MIP Insurance							17,107	17,107			36
37	**TOTAL Ownership**			1,664,732	1,664,732		1,664,732	(717,764)	946,968			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		87,268	195,208	282,476		282,476	(129,454)	153,022			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,700	164,700		164,700		164,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		87,268	359,908	447,176		447,176	(129,454)	317,722			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,559,672	721,477	4,116,357	8,397,506	1,483	8,398,989	(1,704,351)	6,694,638			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	159,105	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,529)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(4,000)	32		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,650)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)	27		24
25	Fund Raising, Advertising and Promotional	(23,960)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(861)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 106,105		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(871,539)	vary	34
35	Other- Attach Schedule **see pg 5a**	(938,917)	vary	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,810,456)		36
37	**(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))**	$ (1,704,351)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Alden Wentworth Rehab & HCC

ID# 0026435

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	non-cost part b therapy c/a (part of gls 5212/3/4)	$ (1,611)	39	1
2	non-cost: hmo nursing supply c/a gl 5026	(1,441)	39	2
3	non-cost: hmo oxygen c/a gl 5080	(2,000)	39	3
4	non-cost: hmo therapy c/a gl 5040	(30,691)	39	4
5	non-cost: hmo drugs c/a gl 5042	(7,955)	39	5
6	MORTGAGE INTEREST	250,408	32	6
7	ELIMINATE RENT DUE TO SALE/LEASEBACK	(1,176,050)	34	7
8	MORTGAGE INTEREST PREMIUM	17,107	36	8
9	HOLIDAY / VAC / SICK PRIOR YEAR ADJ (5306)	1,631	22	9
10	HELP WANTED ADV (gl 5724)prior year exp adj.	1,083	20	10
11	COMMUNITY RELATIIONS (gl 5726)	(913)	20	11
12	Reclass painting>$1500 for 2000 from ln 6 to pg 22	(7,141)	6	12
13	record deprec exp on painting reclassed in 1999	6,372	6	13
14	record deprec exp on painting reclassed in 2000	1,190	6	14
15	record deprec exp on painting reclassed in 1998	7,042	6	15
16	record addt'l defer maint deprec exp to reflect actual	4,053	6	16
17				17
18				18
19				19
20				20
21				21
22				22
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83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(938,917)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,529)	0	0	(37,371)	0	0	0	0	0	0	0	(38,900)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	11,516	0	11,874	0	0	0	0	0	0	0	0	23,390	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	9,987	0	11,874	(37,371)	0	0	0	0	0	0	0	(15,510)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(405)	0	0	0	0	0	0	(405)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	(405)	0	0	0	0	0	0	(405)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(962,028)	0	0	0	0	(119)	0	0	0	(962,147)	19
20	Fees, Subscriptions & Promotions	(29,301)	0	750	0	0	0	0	0	0	0	0	(28,551)	20
21	Clerical & General Office Expenses	0	0	49,977	19,237	5,124	0	0	0	0	0	0	74,338	21
22	Employee Benefits & Payroll Taxes	1,631	0	72,096	0	(123)	0	0	0	0	0	0	73,604	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	19,334	0	0	0	0	0	0	0	0	19,334	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	205	0	0	0	0	0	0	0	0	205	26
27	Other (specify):*	(18,000)	0	0	0	0	0	0	0	0	0	0	(18,000)	27
28	**TOTAL General Administration**	(45,670)	0	(819,666)	19,237	5,001	0	0	(119)	0	0	0	(841,217)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(35,683)	0	(807,792)	(18,134)	4,596	0	0	(119)	0	0	0	(857,132)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	159,105	0	15,315	0	0	0	0	0	0	0	0	174,420	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	957	0	0	0	0	957	31
32	Interest	246,408	0	6,777	0	0	0	1,584	0	0	0	0	254,769	32
33	Real Estate Taxes	0	0	8,380	0	0	0	0	0	0	0	0	8,380	33
34	Rent-Facility & Grounds	(1,176,050)	0	0	0	0	0	0	0	0	0	0	(1,176,050)	34
35	Rent-Equipment & Vehicles	0	0	2,653	0	0	0	0	0	0	0	0	2,653	35
36	Other (specify):*	17,107	0	0	0	0	0	0	0	0	0	0	17,107	36
37	**TOTAL Ownership**	(753,430)	0	33,125	0	0	0	2,541	0	0	0	0	(717,764)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(43,698)	0	0	(14,851)	(17,980)	0	(52,925)	0	0	0	0	(129,454)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(43,698)	0	0	(14,851)	(17,980)	0	(52,925)	0	0	0	0	(129,454)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(832,812)	0	(774,667)	(32,985)	(13,384)	0	(50,384)	(119)	0	0	0	(1,704,351)	45

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ALDEN MANAGEMENT SERV., INC.	100%	SEE PG. 6K-TOO MANY TO FIT HERE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	maintenance/utilities	$	Alden Management Services, Inc.	100.00%	$ 11,874	$ 11,874	15
16	V	19	professional fees	978,300	Alden Management Services, Inc.		16,272	(962,028)	16
17	V	20	licenses/fees		Alden Management Services, Inc.		750	750	17
18	V	21	gen'l & admin		Alden Management Services, Inc.		49,977	49,977	18
19	V	22	employee costs		Alden Management Services, Inc.		72,096	72,096	19
20	V	24	auto/seminar		Alden Management Services, Inc.		19,334	19,334	20
21	V	26	insurance		Alden Management Services, Inc.		205	205	21
22	V	30	depreciation		Alden Management Services, Inc.		15,315	15,315	22
23	V	32	interest		Alden Management Services, Inc.		6,777	6,777	23
24	V	33	real estate tax		Alden Management Services, Inc.		8,380	8,380	24
25	V	35	auto lease		Alden Management Services, Inc.		2,653	2,653	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 978,300			$ 203,633	$ * (774,667)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	tube feeding	$ 65,334	Pyramid Healthcare Services	0.00%	$ 27,963	$ (37,371)	15
16	V	39	nursing supplies	11,625	Pyramid Healthcare Services		3,127	(8,498)	16
17	V	39	supplies / per diem fees	17,648	Pyramid Healthcare Services		11,295	(6,353)	17
18	V	21	general & administrative		Pyramid Healthcare Services		19,237	19,237	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 94,607			$ 61,622	$ * (32,985)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	$ 53,499	Forum Extended Care II	0.00%	$ 40,270	$ (13,229)	15
16	V	10	house stock	1,638	Forum Extended Care II		1,233	(405)	16
17	V	39	iv	19,216	Forum Extended Care II		14,465	(4,751)	17
18	V	22	employee vaccinations	497	Forum Extended Care II		374	(123)	18
19	V	21	general & administrative		Forum Extended Care II		5,124	5,124	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,850			$ 61,466	$ * (13,384)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	CPT REVENUES	$ 136,826	COMMUNITY PHYSICAL THERAPY	100.00%	$ 83,901	$ (52,925)	15
16	V	31	AMORTIZATION		COMMUNITY PHYSICAL THERAPY		957	957	16
17	V	32	INTEREST		COMMUNITY PHYSICAL THERAPY		1,584	1,584	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 136,826			$ 86,442	$ * (50,384)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	construction management fees	$ 8,465	ALDEN BENNETT CONSTRUCTION	0.00%	$ 8,346	$ (119)	15
16	V	19	design fees	386	ALDEN DESIGN		386		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,851			$ 8,732	$ * (119)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Floyd Schlossberg	President-AMS	CEO	100.00%	179,727	3.028	7.57	Salary	$ 14,719	21-1	1
2	Lauren Magnussen	Clinical Coordinator	Nursing Review	a	68,852	3.028	7.57	Salary	5,639	21-1	2
3	Terry Magnusson	Administrator/other	Admin/Maint	b	71,298	3.028	7.57	Salary	2,323	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10	a. Lauren Magnusson is the caughter of Floyd Schlossberg and worked as a Clinical Coordinator for Alden Management Services for all of 2000.										10
11	b. Terry Magnusson is the son-in-law of Floyd Schlossberg and worked as the Administrator of Alden - Valley Ridge for 7 months thereafter he worked as in										11
12	Construction/Maintenance for Alden Management Services.										12
13								TOTAL	$ 22,681		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc.
Street Address: 4200 W. Peterson
City / State / Zip Code: Chicago, Illinois 60646
Phone Number: (773) 286-3883
Fax Number: (773) 286 - 3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		SEE PAGE 8A								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	PRO FORMA ALLOCATION						$	$			$	1
2	OF MORTGAGE INTEREST											2
3	RESULTING FROM SALE/											3
4	LEASEBACK		X	MORTGAGE	$33,979.00	11/82	5,163,656	3,238,601	2012	0.0750	250,408	4
5												5
	Working Capital											
6	RELATED PARTY - AMS	X		OPERATIONS	NONE					VARIES	6,777	6
7	RELATED PARTY - CPT	X		OPERATIONS	NONE					VARIES	1,584	7
8	LINE OF CREDIT		X	OPERATIONS	NONE					VARIES	53,636	8
9	TOTAL Facility Related				$33,979.00		$ 5,163,656	$ 3,238,601			$ 312,405	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,163,656	$ 3,238,601			$ 312,405	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	371,934	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	351,845	2
3. Under or (over) accrual (line 2 minus line 1).	$	(20,089)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	369,438	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	349,349	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	348,513	8
	1996	357,088	9
	1997	348,044	10
	1998	354,223	11
	1999	351,845	12

LINE 4: 2000 ACCRUAL BASED ON 5% INCREASE OR PRIOR YEAR BILL: $351,845*1.05=369,438

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,814 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BUILDING	71,388		$ 132,641	1
2					2
3	TOTALS	71,388		$ 132,641	3

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6	300		1981	1981	5,261,267		35	150,322	150,322	2,953,372	6
7											7
8											8
	Improvement Type**										
9	PAVING/UTILITY WORK/LANDSCAPING			1981	309,353		10-40	7,393	7,393	178,378	9
10	TILE			1982	1,873		10			1,873	10
11	METAL TRIMWORK/TILE/NURSE STATION/A/C			1983	3,286		8-20			3,286	11
12	GRAB BARS/ELECTRICAL WORK/CARPENTRY			1984	42,456		3-27	1,390	1,390	35,904	12
13	BOILER			1985	4,000		10			4,000	13
14	RESURFACING/TUCKPOINTING/FREEZER REPAIR/MOTORS-VAR			1986	52,147		3-5			52,147	14
15	HEATING REPAIRS			1987	3,410		10			3,410	15
16	GLASS/PUMP REPAIRS/ELECTRICAL WORK			1988	13,872		5-10			13,872	16
17	CONDENSOR REPAIR/HVAC-MISC./CONSTRUCTION			1990	58,637	1,147	5-10	1,147		58,637	17
18	CLEAN BOILER/TV SERVICE/REPAIR TOWER BELTS/GLASS			1991	61,199	1,626	5-10	1,626		60,657	18
19	WIRE PARTITIONING/TRANSFER BOX/PIPING/DRAIN/MOTOR/DA			1993	33,591	2,146	5-15	2,146		20,027	19
20	PLUMBING/ELEVATOR/PUMP MOTOR/SINK TOPS/BOILER			1994	28,780	1,561	15-20	1,561		10,257	20
21	TILE WORK/DOOR FRAMES/FILTER&PUMP ASSEMBLY/WATER T			1995	27,562	2,706	10-12	2,706		15,598	21
22	PLUMBING REPAIR (GREAT LAKES)			1996	4,560	456	10	456		2,166	22
23	REPAIR RAMP LIGHTING			1996	1,600	160	10	160		707	23
24	INSTALL NEW FLOORING			1996	2,800	140	20	140		630	24
25	INSTALL NEW FLOORING			1996	1,763	88	20	88		382	25
26	INSTALL NEW FLOORING			1996	2,800	140	20	140		642	26
27	INSTALL NEW FLOORING			1996	2,800	140	20	140		716	27
28	REPAIRED ROOF			1996	1,675	168	10	168		810	28
29	TV ANTENNA & OUTLETS			1997	2,298	460	5	460		1,723	29
30	SUPERIOR (REPAVEMENT)			1997	3,305	661	5	661		2,203	30
31	CLIMATE SERV.(BOILER PARTS)			1997	4,938	988	5	988		3,292	31
32	CLIMATE SERV.(BOILER REPAIR)			1997	4,820	964	5	964		3,053	32
33	CLIMATE SERV.(INSTALL TUBES FOR HVAC)			1997	4,742	948	5	948		2,924	33
34				1992							34
35	continued on next page…										35
36	TOTAL (lines 4 thru 35)				$ 5,939,534	$ 14,498		$ 173,603	$ 159,105	$ 3,430,666	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	EJECTOR PUMP/HVAC REPAIRS			1992	35,689	1,611	5-15	1,611		30,308	9
10	WIGDAHL(REPAIR LIGHTING & LAMPS)			1998	3,886	777	5	777		2,331	10
11	LONG ELEV.(INSTALLED DOOR RESTRICTORS)			1998	5,100	255	20	255		723	11
12	MIDWEST(REPLACE BOOSTER HEATER)			1998	3,359	336	10	336		924	12
13	MR.ROOTER(REPAIR INJECTOR PUMPS)			1998	5,100	510	10	510		1,148	13
14	MR.ROOTER(REPAIR BASEMENT EJECTOR PMP)			1998	2,600	260	10	260		542	14
15	CLIMATE SERVICE(REPLACE HOT WATER PUMP)			1998	6,237	416	15	416		866	15
16	ABC - TANK REPLACEMENT			1999	12,409	827	15	827		1,655	16
17	Alden Bennett Construction (waiting for invoice)			1999	11,000	1,100	10	1,100		2,017	17
18	North Town Food Service (install booster heater)			1999	1,674	167	10	167		321	18
19	Climate Service, INC. (PVI water heater)			1999	11,150	743	15	743		1,115	19
20	Fox Valley Fire & Safety(sprinkler system repair)			1999	2,690	179	15	179		254	20
21	Alden Bennett Construction (carpentry labor)			1999	5,954	595	10	595		843	21
22	Alden Bennett Construction (specialty products)			1999	4,647	465	10	465		658	22
23	Capps Plumbing & Sewer, Inc.(lavatory faucets)			1999	3,390	339	10	339		452	23
24	Fox Valley Fire & Safety(fiire alarm system)			1999	2,981	199	15	199		248	24
25	Alden Bennett Construction (Hardware)			1999	1,843	184	10	184		200	25
26	ABC-leasehold improv-construction			2000	5,384	269	10	269		269	26
27	ABC-leasehold improv-construction			2000	1,518	89	10	89		89	27
28	Climate Service (A/C Repair)			2000	9,393	1,722	5	1,722		1,722	28
29	Capps Plumbing & Sewer (Kitchen Repair)			2000	2,842	568	5	568		568	29
30	Capps Plumbing & Sewer (Kitchen Repair-faucets)			2000	2,890	289	10	289		289	30
31	Kraft Paper Sales Co (Inside Garbage to Dumpser)			2000	1,258	115	10	115		115	31
32	Kraft Paper Sales Co (Walkoff Matts)			2000	1,884	345	5	345		345	32
33	New Horizons (telephone repair)			2000	3,756	313	10	313		313	33
34	Fox Valley Fire & Safety (smoke detector wiring)			2000	5,482	305	15	305		305	34
35	Patten Industries (heating repair)			2000	3,012	502	5	502		502	35
36	TOTAL (lines 4 thru 35)				$ 157,128	$ 13,481		$ 13,481	$	$ 49,122	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Equipment International (doorlock electronic timer)			2000	1,655	152	10	152		152	9
10	DePaul Plumbing (installation of 1 1/2" water line)			2000	5,483	183	25	183		183	10
11	System Electric (sprinkler pump motor & wiring)			2000	2,990	150	15	150		150	11
12	System Electric (various kitchen & laundry repairs)			2000	4,605	691	5	691		691	12
13	D.B.S Contracting (automatic lawn sprinkler system)			2000	44,985	1,200	25	1,200		1,200	13
14	GT Mechanical (HCVAC Repairs)			2000	439	51	5	51		51	14
15	Patten Industries (batteries for generator)			2000	1,857	155	5	155		155	15
16	GT Mechanical (replace cooling coils in hallway air unit)			2000	2,500	146	10	146		146	16
17	GT Mechanical(replace cooling coils in hallway air unit)			2000	14,200	828	10	828		828	17
18	Capps Plumbing (rebuilt toilet, two handle lavatory)			2000	2,395	146	15	146		146	18
19	Capps Plumbing (repair scullery drain install faucets)			2000	3,446	316	10	316		316	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 84,555	$ 4,017		$ 4,017	$	$ 4,017	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related Party			1978	$ 12,184	$ 554	22	$ 554	$	$ 11,565	4
5	Related Party			1978	5,953	271	32	271		4,767	5
6	(FORUM)										6
7											7
8											8
	Improvement Type**										
9	Related Party - AMS:			1993	5,378	223	various	223		115,184	9
10	Leasehold Improvement - Remodeling			1994	2,663	407	various	407		55,299	10
11	Leasehold Improvement - Remodeling										11
12											12
13	Related Party - Forum:			1980	19,102	955	20	955		19,102	13
14	Leasehold Improvement - Remodeling			1980	113		10			113	14
15	Leasehold Improvement - Remodeling			1986	32		6			32	15
16	Leasehold Improvement - Remodeling			1990	51		5			51	16
17	Leasehold Improvement - Remodeling			1991	12		5			12	17
18	Leasehold Improvement - Remodeling			1993	4,085	408	10	408		4,085	18
19	Leasehold Improvement - Remodeling			1993	3,199	330	9.7	330		3,058	19
20	Leasehold Improvement - Remodeling			1994	258	21	10	21		145	20
21	Leasehold Improvement - SIGN			1994	437	44	12	44		244	21
22	Leasehold Improvement - DRYVIT			1995	714	48	10	48		71	22
23	Leasehold Improvement - NEW AC			1997	961	51	10	51		760	23
24	Leasehold Improvement - Roof			1998	853	57	10	57		369	24
25	Leasehold Improvement - Roof			1985	809	54	19	54		175	25
26	Leasehold Improvements-Roof			1999	1,373	92	15	92		198	26
27	Leasehold Improvements-Roof										27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 58,178	$ 3,514		$ 3,514	$	$ 215,231	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 497,447	$ 43,423	$ 43,423	$	various	$ 270,925	37
38	Current Year Purchases	26,381	2,369	2,369		various	2,369	38
39	Fully Depreciated Assets	50,023	1,214	1,214		various	50,023	39
40								40
41	TOTALS	$ 573,851	$ 47,006	$ 47,006	$		$ 323,317	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	various	busses, van, engines	1998-2000	$ 26,682	$ 2,494	$ 2,494	$	3	$ 3,030	42
43										43
44										44
45										45
46	TOTALS			$ 26,682	$ 2,494	$ 2,494	$		$ 3,030	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 6,972,569	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 85,010	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 244,115	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 159,105	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 4,025,383	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: OMEGA HEALTHCARE INVESTORS

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1978	300		$ 1,132,463	5		3
4	Additions							4
5								5
6								6
7	TOTAL		300		$ 1,132,463 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: RIGHT OF FIRST REFUSAL @ *

10. Effective dates of current rental agreement:
Beginning 10/30/96
Ending 10/30/00

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 1,176,050
13.	/2002	$ 0
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 12,002 Description: COPY MACHINE LEASE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	RELATED PARTY	VARIOUS	$ #######	$ 26,503	17
18					18
19					19
20					20
21	TOTAL		$ #######	$ 26,503	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   SKILLED NURSING IS ALREADY ON SITE

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 67,575	$		$ 67,575	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,856			3,856	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			63,093			63,093	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	SEE PG 16A…	# of prescrpts				33,799		33,799	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	SEE PG 16A…					(15,301)		(15,301)	13
14	TOTAL			$		$ 134,524	$ 18,498		$ 153,022	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Alden Wentworth Rehab & HCC **#** 0026435 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 12,575	$	1
2	Cash-Patient Deposits	69,830		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (59,000))	1,712,629		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	195,178		6
7	Other Prepaid Expenses	408		7
8	Accounts Receivable (owners or related parties)	2,496,216		8
9	Other(specify): medicare receiv/misc	158,116		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,644,952	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	799,132		15
16	Equipment, at Historical Cost	503,791		16
17	Accumulated Depreciation (book methods)	(751,614)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 551,309	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,196,261	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,519,351	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	67,427		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	303,868		30
31	Accrued Taxes Payable (excluding real estate taxes)	57,266		31
32	Accrued Real Estate Taxes(Sch.IX-B)	369,438		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	555,637		35
	Other Current Liabilities(specify):			
36	due from third parties	416,286		36
37	accrued expenses	675,608		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,964,880	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,964,880	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 232,864	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,197,744	$	48

***(See instructions.)**

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,523,638	1
2	Restatements (describe):		2
3	**external auditors' adjustments made after 1999 cost report**		3
4	**was filed: the adjustments do not relate to allowable costs:**		4
5	**bad debts and medicare revenue were affected.**	(391,203)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,132,435	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(899,571)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (899,571)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 232,864	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,940,985	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,940,985	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(9,834)	6
7	Oxygen	13,701	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,867	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	93	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	51,805	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 51,898	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Expense adjustments relating to prior years. Since prior	4,331	28
28a	yr rep weren't used we dinn't back it out on p 5 or 5A.		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,331	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,001,097	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,608,408	31
32	Health Care	2,365,728	32
33	General Administration	1,814,624	33
	B. Capital Expense		
34	Ownership	1,664,732	34
	C. Ancillary Expense		
35	Special Cost Centers	282,476	35
36	Provider Participation Fee	164,700	36
	D. Other Expenses (specify):		
37	Note: this does not balance to pg 3 & 4 due to related party		37
38	amounts on page 3 & 4.		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,900,668	40
41	**Income before Income Taxes (line 30 minus line 40)****	(899,571)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (899,571)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,859	2,080	$ 75,255	$ 36.18	1
2	Assistant Director of Nursing	1,816	2,208	63,134	28.59	2
3	Registered Nurses	5,975	6,375	131,811	20.68	3
4	Licensed Practical Nurses	48,440	52,413	892,848	17.03	4
5	Nurse Aides & Orderlies	105,665	114,953	909,071	7.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,816	1,976	20,543	10.40	9
10	Activity Assistants	8,874	9,612	58,451	6.08	10
11	Social Service Workers	1,568	1,726	29,634	17.17	11
12	Dietician					12
13	Food Service Supervisor	1,912	2,080	49,142	23.63	13
14	Head Cook	6,240	7,035	57,202	8.13	14
15	Cook Helpers/Assistants	20,684	23,144	177,873	7.69	15
16	Dishwashers					16
17	Maintenance Workers	1,352	1,368	35,821	26.18	17
18	Housekeepers	33,637	36,856	264,021	7.16	18
19	Laundry	8,910	9,655	77,324	8.01	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	3,912	4,182	61,183	14.63	22
23	Office Manager	4,563	5,044	43,316	8.59	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,419	3,920	69,431	17.71	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Clinical supervisor	1,920	2,160	46,775	21.66	33
34	TOTAL (lines 1 - 33)	262,562	286,787	$ 3,062,835 *	$ 10.68	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	2,524	11-3	44
45	Social Service Consultant	16	824	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	65	$ 3,348		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CLARENCE BOYKIN	ADMINISTRATOR		$ 89,631
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,631

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALDEN MNGMT. SERVICES	MNGT. FEES	$ 978,300
BLACKMAN KALLICK	ACCT. FEES	11,400
KEN. J. FISCH	LEGAL FEES	20,970
GREENBURG & HERMAN	LEGAL FEES	4,742
MISC. LEGAL EXP	LEGAL FEES	281
ACHIEVE ACCREDITATION	JHCACO Consultant	2,894
GATES MCDONALD	Unemployment Comp.	971
MISC. PROF FEES	PROF. FEES	737
PROF. FEES ALDEN DESIGN	PROF. FEES	386
PROF. FEES ABC	PROF. FEES	8,465
US GAS	Utility Consultant	1,350
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,030,496

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,942
Unemployment Compensation Insurance	43,299
FICA Taxes	227,542
Employee Health Insurance	43,999
Employee Meals	41,438
Illinois Municipal Retirement Fund (IMRF)*	
Chicago head tax	7,442
RELATED PARTY	71,973
UNION HEALTH & WELFARE	51,397
DENTAL / LIFE / INSURANCE	889
EMP RELATIONS / TUITION REIMBURS	3,129
PENSION / EMP VACC /	23,565
401 K MATCH	1,116
TOTAL (agree to Schedule V, line 22, col.8)	$ 567,731

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
RELATED PARTY	750
CITY OF CHICAGO / LICENSE	2,037
MISC. INSPECTIONS	415
MISC. SUBSCRIPTIONS	244
IHCA	9,764
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,210

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
AUTO & TRAVEL	1,369
Seminar Expense	
EMP. SEMINARS	174
RELATED PARTY	19,334
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,877

**See instructions.

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	This page is a summary of items. For		$		$	$	$	$	$	$	$	$	$
2	details, see pages 22A-												
3	22E . . .												
4													
5	See Page 22A	2/89-12/89	43,571	5									
6	See Page 22A	4/90-12/90	14,230	5									
7	See Page 22A & 22B	5/91-12/91	34,034	3-5	0								
8	See Page 22B	1/92-12/92	32,973	5	2,729	0							
9	See Page 22B	11/93	1,495	5	299	249	0						
10	See Page 22B	12/94	3,927	3	1,200	0							
11	See Page 22C	2/95-1295	30,435	3-20	6,600	3,805	1,474	1,182	1,124	1,124	1,124	1,124	1,124
12	See Page 22C & 22D	1/96-12/96	43,836	3-20	10,681	10,681	6,214	1,356	1,356	1,356	1,356	1,356	1,356
13	See Page 22C & 22D	2/97-12/97	32,043	3	4,470	10,681	10,681	6,211	0				
14	See Page 22D	1/98-12/98	32,985	3		5,319	10,995	10,995	5,676	0			
15	See Page 22D	3/99-8/99	30,523	3			5,533	10,174	10,174	4,641	0	0	0
16	See Page 22E	3/00-6/00	44,766	3				9,081	14,922	14,922	5,841	0	0
17													
18													
19													
20	TOTALS		$ 344,818		$ 25,979	$ 30,735	$ 34,897	$ 38,999	$ 33,252	$ 22,043	$ 8,321	$ 2,480	$ 2,480

Facility Name & ID Number Alden Wentworth Rehab & HCC # 0026435 Report Period Beginning: 1/1/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Health Care Assoc. $14,196**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,569** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **YES**
If YES, give effective date of lease. **10/30/96**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **164,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **41,438** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Blackman Kallick Bartelstein, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **NOT YET COMPLETED**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.